pertension (about 140/90), mild elevations in any one or more of a number of laboratory values (uric acid, γ-glutamyl transferase, triglycerides, mean corpuscular volume) or have symptoms of insomnia, impotence or depression. The diagnosis is made by asking a patient (and spouse, if appropriate) about the pattern of life problems and then determining whether alcohol was a contributor. These problem areas include family (a separation or divorce related to alcohol), police (two or more alcohol-related arrests or accidents), job (an alcohol-related loss or layoff) and health (physical evidence that alcohol intake had harmed health, including a history of alcohol withdrawal). Once alcoholism has been identified, confrontation entails reminding patients that they are responsible for their own actions, pointing out ways in which alcohol use has significantly interfered with their life, noting that a long and healthy life will require abstinence and referring them to a treatment program or Alcoholics Anonymous (or both).

The prognosis in alcoholism is good. The chances that a patient will achieve and maintain abstinence for an extended time (longer than a year) increase with the patient's level of stability before entering care. Thus, a person who has an intact family, a job or relevant job skills and an absence of drug problems or non-alcohol-related police difficulties has a 70% chance of being abstinent for one to two years.

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Car Passenger Injuries and Child Restraints

THE USE OF appropriate restraining devices (car seats and safety belts) for child car passengers is truly an idea whose time has come. Few health service agencies, such as hospitals, clinics, medical or dental offices, pharmacies or health departments, actively promoted these devices until a short while ago. For children under 15 years, car passenger injuries represent the single leading cause of death in the United States, almost 2,000 fatalities per year.

The younger a child, the more vulnerable he or she is to severe injury or death. Considering the anatomic proportions of children, this finding is not surprising: a relatively higher center of gravity makes a child, when unrestrained, serve as a projectile hurled inside or outside a car when it is stopped by a crash or sudden braking. The "typical" child victim is a 1-year-old who rode unrestrained in the front seat of the family car, and the injury occurred during the daylight hours and in ordinary weather and road conditions.

There is no question that child restraints provide significant protection; unrestrained children are more than ten times as likely to sustain severe injury or death. Tennessee, the first state to enact mandatory child restraint legislation in 1978, reports a provisional 50% reduction in fatalities. About 30 other states have recently enacted similar legislation mandating car seat or safety belt use by young children.

Through education of their parents, children should be protected against car passenger injuries. Ideally this activity should be initiated during the prenatal period and proceed on through infant restraints to include the use of safety belts by school-age children. This simple, sensible and safe practice will not be easy to implement universally but can be accomplished through a combination of health education, legislation and the development of an increased personal sense of health and safety.

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Screening for Colorectal Cancer

COLORECTAL CANCER is the second most common type of cancer (excluding skin cancer) in the United States. In 1983 there will be an estimated 126,000 new cases (87,000 colon and 39,000 rectal) with about 58,000 deaths.

The American Cancer Society has issued the following guidelines for colorectal cancer checkups:

- Men and women over 50 years of age should have a test for occult blood in the stool every year;
- men and women over 50 years of age should have annual sigmoidoscopic examinations until two consecutive examinations are normal and thereafter every three to five years, and
- men and women over 40 years of age should have a digital rectal examination yearly.

Persons who are at a high risk of colorectal cancer developing should receive more frequent and intensive examinations beginning at an earlier age. High-risk groups include persons with a history of adenomatous colon polyps or prior colon cancer, Gardner's syndrome, ulcerative colitis, familial polyposis or a family history of colorectal cancer.

The National Cancer Institute's consensus report states that the stool blood test should not be used as yet for screening, until the outcome of ongoing clinical trials shows a decrease in colorectal cancer mortality. The Canadian Cancer Society recommends that the screening use of stool blood test be used only for persons at high risk.

One must realize that most but not all colorectal cancer patients will have occult blood in the stool and that some but not all precancerous colorectal lesions (for example, adenomatous polyps) will bleed; other non-neoplastic conditions may give a positive test for

blood. One must also accept the cost and risk of the workup when occult blood is found in stool specimens, to be able to detect colorectal cancer at an earlier stage and improve the prognosis. I favor the American Cancer Society's recommendations for the present instead of awaiting the results of clinical trials.

The International Workgroup on Colon Rectal Cancer has recommended that fecal occult blood testing be done annually beginning between the ages of 40 and 50 years.

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Prevention of Hepatitis B Virus Infections From Mothers to Infants

WHILE RELATIVELY UNCOMMON in the United States, chronic infection with hepatitis B virus (HBV) may be found in up to 15% of the population in many developing countries. A significant proportion of these infections occurs as a result of mother-to-infant transmission. Persons chronically infected with HBV, especially those infected at birth or early in life, are at increased risk of subsequent liver disease such as chronically active hepatitis, cirrhosis and primary hepatocellular carcinoma.

In California alone (an area of low incidence), an estimated 3,000 to 5,000 women who are positive for hepatitis B surface antigen (HBsAg) give birth each year. Most mother-to-infant infections seem to occur at the time of delivery (connatal) or shortly thereafter, rather than transplacentally. The probability of exposed neonates becoming HBV carriers can be greatly reduced by administering hepatitis B immune globulin. The Public Health Service Immunization Practices Advisory Committee (ACIP) recommended in 1981 that all infants born to HBsAg-positive mothers should be given 0.5 ml of hepatitis B immune globulin immediately after birth and at three and six months. The Committee on Infectious Diseases of the American Academy of Pediatrics has made a similar recommendation.

In June 1982 the ACIP recommended that infants born to HBV-infected mothers should also receive hepatitis B virus vaccine, in addition to the three doses of hepatitis B immune globulin, inasmuch as these infants may continue to be at risk of infection from their mothers and other possible carriers in the household. The optimal timing for giving the vaccine in conjunction with hepatitis B immune globulin has not yet been established. Until additional data are available, however, the ACIP has recommended that immunization with hepatitis B virus vaccine should be started at three months of age, or shortly thereafter.

To carry out appropriate prophylactic measures in the delivery room, it is necessary to know before delivery whether the mother has the hepatitis B surface antigen. The HBsAg carrier rate in the US population ranges from 0.1% to 0.5%. Much higher HBsAg carrier rates are found in persons from hyperendemic hepatitis B virus areas of the world, such as Asia, Subsaharan Africa and the Pacific Islands. Persons of Asian ancestry born in the United States appear to maintain relatively high HBsAg carrier rates. There are thus clear indications for doing routine prenatal HBsAg testing of women who are members of groups with HBsAg carrier rates of 1% or more. In addition to the ethnic minorities already mentioned, these groups include women who have acute or chronic liver disease, frequent occupational exposure to blood, household or sexual contacts of known HBsAg carriers and women with a history of injecting illicit drugs.

The prevention or modification of hepatitis B virus infections in infants deserves high priority as there is no present cure or treatment for the chronic HBsAg carrier state once it is established. Additionally, failure to identify pregnant carriers in the known high-risk groups can expose health care providers to an increased risk of nosocomial hepatitis B and to possible legal action on behalf of those infants in whom the chronic carrier state might develop because of the failure to provide any prophylaxis.

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Pesticides as a Public Health Concern in California

CALIFORNIA LEADS the nation both in the volume of pesticides used and in the number of pesticide-related illnesses. In 1981 the statewide use was 218 million kg (480 million lbs) of pesticides, 78% of which was for agriculture, the remainder for home, garden, structural and industrial use. Last year, 1,388 illnesses related to occupational exposure to pesticides were documented in the state, 48% of which involved systemic symptoms, the rest being skin and eye conditions. This information is based on physicians' reports of pesticide illness and investigations by agricultural and public health agencies. The State Health and Safety Code requires that any physician "who knows, or has reasonable cause to believe, that a patient is suffering from pesticide-related illness" must report the case to the local health officer within 24 hours; also, in work-related illness, a "Physician's First Report" of illness must be filed within seven days. Failure to comply with the reporting requirement renders the physician liable for a civil penalty of $250.

The high-risk occupations for systemic pesticide illness are mixing, loading and applying of pesticides,